

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027912  
STATE FILE NUMBER

FILED JUL 21 1958 Registration District No. 333 Primary Registration District No. 3024 Registrar's No. 120

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>		c. CITY OR TOWN <b>Sikeston</b> 10030 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hosp.</b>		d. STREET ADDRESS <b>Dorothy St.</b> (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b <b>19 Days</b>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Delone</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>4</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>Male</b> 0	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-9-1874</b>
9. AGE (In years last birthday) <b>83</b>		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Tommy Carroll, Sikeston, Mo.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>332 X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>3 yrs</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> Month, Day, Year <b>p. m.</b>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <b>Morehouse, Mo.</b>		COUNTY STATE	
21. I attended the deceased from <b>2/5/58</b> to <b>4/2/58</b> and last saw her alive on <b>4/2/58</b> Death occurred at <b>12:10 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Legible or title) <b>Ralph Franklin, M.D.</b>		22b. ADDRESS <b>Morehouse, Mo.</b>	
22c. DATE SIGNED <b>4/4/58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-4-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carpeinter</b>	23d. LOCATION (City, town, or county) (State) <b>Frank City Mo</b>
24. FUNERAL DIRECTOR <b>Broville Taylor Roberts</b>		25. DATE RECD. BY LOCAL REG. <b>7-8-58</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Ella Hunter</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DATE RECEIVED 7-14-58

SCOTT CO. HEALTH DEPT.

CO. FILE No. 758-165

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Paul S. Marshall

Licensed Embalmer No. 40

P. O. Address Liberty

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.